WITHIN CORPORATE LIMITS.

M

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10200

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 hr.

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Main St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Premature Infant Baer

**3. (b) Social Security Number** ✓

4. Sex: ~~Male~~

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Stillborn

6 (b) Name of husband or wife ✓

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct. 12th 1940

**8. AGE:** Years ✓ Months ✓ Days ✓ If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland, Md Alleg.
(Town, county, and state)

10. Usual occupation ✓

11. Industry or business ✓

FATHER
12. Name Adam Baer
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden name Lois Grove
15. Birthplace Thomastown Pa.

16. Informant Dr. Adam Baer

Address 44 W. Main St.

17. ~~Bu~~ Cremation
(Burial, cremation, or removal. Which?)

Date thereof Oct 14, 1940
(month) (day) (year)

Cemetery or crematory Hafers Crematory

Location Frostburg, Md

18. Funeral director Jacob Hafer

Address Frostburg, Md

19. Oct. 14 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1940, at 12 31 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1940 to Oct. 12 1940, and that I last saw him alive on Stillborn 19

Immediate cause of death: Prematurity (4½ mo. gestation)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other

Address 40 N. Liberty St. Date signed 10-12-40

RECEIVED
NOV 6 1940
BUREAU V. S.

10201

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

**1. PLACE OF DEATH:**

County Mt Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Calla Hill.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Calla Hill.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Samuel Mitchell Barncord

**3. (b) Social Security Number** 0

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Minnie Barncord

6(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Aug. 27 - 1861

**8. AGE:** Years 79 | Months 1 | Days 8 | If less than one day ___ hrs. ___ min.

9. Birthplace: Corrigansville Md (Town, county, and state)

10. Usual occupation: Retired Carpenter

11. Industry or business: Union Mining Co.

FATHER

12. Name: Henry Barncord

13. Birthplace: Md

MOTHER

14. Maiden name: Catharine Geary

15. Birthplace: Md.

16. Informant: Raymond Himmelwright

Address: Mt Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7 1940 (month) (day) (year)

Cemetery or crematory: Episcopal Cemetery

Location: Mt Savage Md.

18. Funeral director: J. J. Durst

Address: Flooding Md.

19. Oct 7 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1940, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1940, to Oct 5 1940 and that I last saw him alive on Oct 5 1940

Immediate cause of death: Chronic Myelitis

DURATION: 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 10/7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 2 1940

10202

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

**1. PLACE OF DEATH:**

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 152. Wood
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Frederick Henry Beck

**3.(b) Social Security Number:** 212-12-8107

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeht Jones Beck

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1870.

**8. AGE:** Years 70 | Months 1 | Days 23 | If less than one day ... hrs. ... min.

9. Birthplace: Martinsburg-Berkley-W.Va.
(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Plup and Paper Mill

FATHER
12. Name: John H. Beck
13. Birthplace: Germany

MOTHER
14. Maiden name: Francis Geiger
15. Birthplace: Germany

16. Informant: William Beck
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 30, 1940 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal.
Address: Westernport, Md.

19. Oct. 30 1940 (Date rec'd by registrar) A J Paynbaker M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 1940, at 6.30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1940, to Oct 28 1940 and that I last saw him alive on Oct - 27 - 1940 1940

Immediate cause of death: Carcinoma of The Bladder

Due to

Due to

Other conditions: Cystitis
(Include pregnancy within 3 months of death)

DURATION: 8 months; 6 months

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: P E Berry, M.D. (M. D. or other)

Address: Piedmont Ida Date signed: 10/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. R.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10203

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 460 Walnut St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 460 Walnut St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Mrs. Margaret E. Bennett

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Albert Bennett

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1872

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 7 | hrs. min. |

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Albert Eschenbacher
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Bopp
15. Birthplace: Germany

16. Informant: Mr. John A. Reed

Address: 460 Walnut St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 26, 1940 (month) (day) (year)

Cemetery or crematory: St. Lukes Cem.

Location: Cumberland, Md.

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Oct 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 23, 1940, at 630 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1940, to Oct 23 1940, and that I last saw h— alive on Oct 22 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 10 days |
| Due to Chronic Nephritis | 2 years |
| Due to Arterio Sclerosis | 5 years |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Geo. A. Franz M. D. or other

Address: Cumberland Md. Date signed 10/24/40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d) tr

10204

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegheny

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 205 Springdale St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 7 mo.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington

City or town outside Hancock Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

**3. (a) FULL NAME** Georgia Anna Bishop

**3. (b) Social Security Number** None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Joseph Bishop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1862

**8. AGE:** Years 78 Months 1 Days 28 If less than one day 11 hrs. 30 min.

9. Birthplace Hancock Washington Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Unknown

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name Georgia Anna Robey

15. Birthplace Hancock Md.

16. Informant Bernard Bishop

Address Hancock Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 1, 1940 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem

Location Hancock

18. Funeral director Snyder-Rowland

Address Hancock Md

19. Oct 30 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1940, at 11 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1940, to Oct 30 1940 and that I last saw her alive on Oct 30 1940.

Immediate cause of death arteriosclerosis myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION Oct 1936

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury Injured at work?

23. SIGNATURE M. S. Owens M. D. or other

Address 133 Va Ave Date signed Oct 30 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940

WITHIN CORPORATE LIMITS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

10205

Reg. Dist. No. 4

**1. PLACE OF DEATH**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 724 Frankford St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 224 Humbird St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Priscilla Jane Buckley

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife: John W. D. Buckley

6.(c) If alive, give age: Years

7. Birth date of deceased (mo., day, yr.): June 9 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 4 | 11 | hrs. min. |

9. Birthplace: W. Va. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: William Loy

13. Birthplace: W Va

MOTHER 14. Maiden name: Priscilla Smith

15. Birthplace: W Va.

16. Informant: Ambrose W Buckley

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 1940 (month) (day) (year)

Cemetery or crematory: St Luke Cem.

Location: Glebe W Va.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Oct 22 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 20, 1940, at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12, 1940, to Oct. 20, 1940 and that I last saw her alive on Oct. 20, 1940

| Immediate cause of death | DURATION |
|---|---|
| Hypertensive Cardio Vascular Disease | 1936. |
| Due to Chronic Myocarditis | |
| Due to Uremia | 10/18/40 |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clay F. Turner M. D. or other

Address: Cumberland Date signed: Oct. 21, 1940

Burrell

RECEIVED
NOV 6 1940
BUREAU V

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

## CERTIFICATE OF DEATH

10206

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City of town: Near Cumberland – Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: Town Creek

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland – Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Town Creek (If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** Richard Wesley Bucey

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6.(b) Name of husband or wife: Nancy Stafford

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1864

8. AGE: Years: 76 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER — 12. Name: William Bucey

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Maryland

16. Informant: Ray Bucey

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6-40 (month) (day) (year)

Cemetery or crematory: Mt. Hermon

Location: W. Va. Rd – Cumberland Md

18. Funeral director: W. L. Lemmerman

Address: Cumberland, Md.

19. Oct 9 1940 (Date rec'd by registrar) D. Bennett Registrar

This burial permit was issued in Cumberland Md. DS

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1940 at 4a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1940 to Oct 4 1940 and that I last saw him alive on Oct 4 – 1940

| Immediate cause of death | DURATION |
|---|---|
| Lymphatic Leukemia Acute | 3 mo. |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ingalls R. Everhart M.D. M. D. or other

Address: 36 Greene St Date signed: 10/4 – 40

RECEIVED
NOV 4 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (835)

## CERTIFICATE OF DEATH

10207

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany.

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Frog Hollow

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** Elizabeth Logsdon Campbell

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: James A Campbell Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17, 1864

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 4 | 25 | ..... hrs. ..... min. |

9. Birthplace: Mt Savage Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Samuel T. Logsdon

13. Birthplace: Pa.

MOTHER

14. Maiden name: Annie Lewis

15. Birthplace: Wales

18. Informant: James Campbell

Address: J. Mt Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15, 1940 (Month) (day) (year)

Cemetery or crematory: Eckhart

Location: Eckhart Md

18. Funeral director: Jacob Hafer

Address: Frostburg Md.

19. Oct. 14 1940 (Date rec'd by registrar) Mrs. A.R. Baker Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 12 1940, at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1940, to Oct. 12 1940.

and that I last saw h.. alive on Oct. 12 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 1 wk. |
| Due to: Arteriosclerosis with hypertension | 10 yrs |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W E Gattens M.D. M. D. or other

Address: Frostburg, Md. Date signed 10/14/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

## CERTIFICATE OF DEATH

10208

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 Day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 330 Cecilia Street
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Mary Ellen Chaney

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Alton Chaney
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1911

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 1 | 2 | ..... hrs. ..... min. |

9. Birthplace: Green County Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Harry E. Malone
13. Birthplace: Uniontown, Pa.
MOTHER 14. Maiden name: Bertha Robison
15. Birthplace: Maryland.
16. Informant: Alton Chaney
Address: 330 Cecilia St. Cumberland
17. burial (Burial, cremation, or removal. Which?) Date thereof: October 8, 1940 (month) (day) (year)
Cemetery or crematory: Davis Memorial
Location: Oldtown Road
18. Funeral director: Louis Stein Inc.
Address: 117 Frederick St. Cumberland, Md.
19. Oct. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-5-40 1940, at 6:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4-40 1940, to 10-5 1940 and that I last saw h alive on 10-5 1940

| Immediate cause of death: Acute Nephritis | DURATION |
|---|---|
| | |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John K. Rozum M D
M. D. or other
Address: Cumberland Md. Date signed: 10/7/40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10209

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 month 20 days

Stay in this community (yrs., or mos., or days) 20 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 103 Frost Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World War - British Army

**3. (a) FULL NAME** John Clark

**3. (b) Social Security Number** 214-16-2785

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 4 | 7 | hrs. min. |

9. Birthplace Glasgow, Scotland (Town, county, and state)

10. Usual occupation Painter

11. Industry or business House Painter

FATHER 12. Name Robert Clark

FATHER 13. Birthplace Glascow, Scotland

MOTHER 14. Maiden name Jessie Walker

MOTHER 15. Birthplace England

16. Informant Mrs James Turner Frostburg, Md.

Address 103 Frost Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29, 1940 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md

18. Funeral director Jacob Hafer

Address Frostburg, Md

19. Oct. 29 (Date rec'd by registrar) 1940 Mrs. A. P. Walker Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 27 1940, at 12:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1940 to Oct 27 1940, and that I last saw him alive on Oct 26 1940.

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 2 yrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane Jr MD M. D. or other

Address Frostburg, Md Date signed 10/28/40

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

## CERTIFICATE OF DEATH

10210

Reg. Diat. No. 4

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 11 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CORRIGANSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** MR. CHARLES S. CLITES

**3.(b) Social Security Number** 705-07-9297

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

8.(b) Name of husband or wife OLIE LOGSDON 8.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) NOV. 19, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 10 | 21 | hrs. min. |

9. Birthplace PENNA. (Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business
FATHER 12. Name DANIEL CLITES
13. Birthplace PENNA.
MOTHER 14. Maiden name SARAH PORTER
15. Birthplace PENNA.
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 13. 1940 (month) (day) (year)
Cemetery or crematory Porters.
Location Hyndman Pa.
18. Funeral director Harvey H. Ziegler
Address Hyndman Pa.
19. Oct 12 1940 (Date rec'd by registrar) J. Franklin M.D. Registrar

**MEDICAL CERTIFICATION** 9:45

20. DATE OF DEATH OCT 10, 1940, at pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT 29, 1940, to OCT 10 1940 and that I last saw him alive on OCT 10, 1940

| Immediate cause of death | DURATION |
|---|---|
| Myocardial degeneration | |
| Arteriosclerosis | |
| Due to | |
| Due to | |
| Other conditions Chronic Bronchitis | |
| Benign Hypertrophy of Prostate | |

(Include pregnancy within 3 months of death)

Major findings of operations Prostatic Resection Date of op. 10-4-40
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Pierson M.D. M. D. or other
Address Cumberland Md Date signed 10-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10211

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 5 hours
Stay in this community (yrs., or mos., or days): 6 weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Corriganville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

**3. (a) FULL NAME:** Robert Carl Clites

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Infant |

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 19, 1940

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 13 | ____ hrs. ____ min. |

9. Birthplace: Cumberland, Allegany Md.
(Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: Daniel Carl Clites
13. Birthplace: Corriganville Md.

MOTHER
14. Maiden name: Julia A. Keating
15. Birthplace: Frostburg, Md.

16. Informant: Daniel C. Clites
Address: Corriganville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5, 1940 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Maryland

16. Funeral director: Jacob Hafer
Address: Cumberland Md

19. Oct. 4 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1940, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept-18 1940, to Oct 2 1940, and that I last saw ~~him~~ alive on Oct 2-40 1940.

| Immediate cause of death | DURATION |
|---|---|
| Whooping-Cough | 2 wks |
| Pneumonia Bronchial | 3 days |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Alfred Vradenburg M. D. or other
Address: Cumberland, Md. Date signed: 10-2-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 6 1940

10212

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Park Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**: Charles Richard Cole

**3. (b) Social Security Number**: None

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Child

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec. 15 - 1938

**8. AGE:** Years: 1 yr | Months: 10 mos | Days: 1 dr | If less than one day: ... hrs. ... min.

9. Birthplace: Frostburg Md.
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER
12. Name: Earnest Cole
13. Birthplace: Frostburg, Md

MOTHER
14. Maiden name: Dianna Williams
15. Birthplace: Frostburg Md.

16. Informant: Ernest Cole
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct-18-1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetary

Location: Frostburg, Md.

18. Funeral director: Jacob Hafer
Address: Frostburg, Md.

19. Oct. 17 1940 (Date rec'd by registrar) Mrs. A. R. Walker, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct 16 19..., at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 19..., to Oct 16 1940 and that I last saw him alive on Oct 16 1940

Immediate cause of death: Bronchopneumonia

Due to: Whooping cough

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: A. M. Earle Jr. M. D. or other

Address: 60 Williamson St. Frostburg Md. Date signed 10-16-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48B)

## CERTIFICATE OF DEATH

10213

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, institution, or street address where death occurred: 53 Greene St.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 53 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Martha Ann Cook

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Jas H. Cook
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): April 29 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 5 | 19 | hrs. min. |

8. Birthplace: Frostburg, Allegany, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home.
FATHER 12. Name: Edward Dufty
13. Birthplace: England
MOTHER 14. Maiden name: Emily Trollet
15. Birthplace: England.
16. Informant: James H. Cook.
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 21 40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.
18. Funeral director: Lomis Stein Sons.
Address: Cumberland.
19. Oct. 21 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1940, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15, 1940, to Oct 18, 1940
and that I last saw her alive on Oct. 15, 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Uterus | June, 1939 |
| Due to: Uraemia | Sept. 15, 1940 |
| Due to: | |
| Other conditions | |

(Includs pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas E. Jones M. D. or other
Address: Cumberland Date signed: Oct. 17, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

10214

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1240)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T) (I) (M)

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 12 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 N. CENTRE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**
MRS. IRENE COOPER

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | BLACK | MARRIED |

6.(b) Name of husband or wife WILLIAM COOPER

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) SEPT. 30, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 0 | 27 | ...hrs. ...min. |

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name SAMUEL DENSON

13. Birthplace MISS.

MOTHER 14. Maiden name MARIA Johnson

15. Birthplace MARYLAND

16. Informant ELIZABETH C. JACKSON

Address 529 N. Centre St., City

17. Burial (Burial, cremation, or Removal. Which?) Date thereof Oct 31 1940 (month) (day) (year)

Cemetery or crematory Woodland Burial Park

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. Oct. 30 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 27, 1940 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13th 1940 to Oct. 27 1940

and that I last saw her alive on Oct. 21 1940

| Immediate cause of death | DURATION |
|---|---|
| Obstruction of the Gallbladder | |
| Due to Hypertension | |
| Due to Biliary Cirrhosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE J. J. Langston M. D. or other

Address 542 N. Mechanic Date signed 10-28-40

RECEIVED
NOV 6 1940

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-E)

10215

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 241 Elder St

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 241 Elder St (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Sydneyan Copeland

**3. (b) Social Security Number:** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Charlie L. Copeland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 12, 1861

**8. AGE:** Years: 73 Months: 11 Days: 29 If less than one day ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: John W. Arndorff

13. Birthplace: Virginia

MOTHER 14. Maiden name: Ezarbell J. Perr

15. Birthplace: Virginia

16. Informant: Mrs. Arthur F. Deter

Address: 241 Elder St.

17. Frank Glover (Burial, cremation, or removal. Which?) Date thereof: Oct 16th 1940 (month) (day) (year)

Cemetery or crematory: St James

Location: Sartannery Va.

18. Funeral director: Louis Stern Jr.

Address: Cumberland, Md.

19. Oct. 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 13 - 1940 at 5:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 - 1940, to Oct. 13 1940 and that I last saw her alive on Oct. 12 1940

Immediate cause of death: Cardiac degeneration

Due to: old age

Due to:

Other conditions: Hyperthyroidism (Include pregnancy within 3 months of death)

DURATION

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. T. Langston M. D. or other

Address: 54 N. Mechanic Date signed: 10-13-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

## CERTIFICATE OF DEATH

10216

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
Allegany hospital
How long in hospital or institution? 1 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 401 Ascension St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME** Rose Marie Crawford.

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 22 1937

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 2 | 10 | hrs. min. |

9. Birthplace: Cumberland, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Charles G. Crawford
13. Birthplace: Cumberland, Maryland

MOTHER
14. Maiden name: Geraldine Hooler
15. Birthplace: Cumberland, Maryland

16. Informant: Charles G. Crawford
Address: Cumberland, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: October 11, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest
Location: Baltimore Pike
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland

19. Oct. 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 1939 to October 8 1940
and that I last saw h[illegible] alive on October 8 1940

Immediate cause of death: Epileptic Convulsions (Grand Mal) — DURATION: 4 hrs.
Due to: Status Epilepticus
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None made

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James J. Johnson, M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 10-9-40

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

10217

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Westernport, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 224 Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Annie Crowe

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife Charles Crowe

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 6, 1870

8. AGE: Years 70 | Months 3 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace Longacoming, Alleg, Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER 12. Name John Brown

13. Birthplace Scotland

MOTHER 14. Maiden name Mary Stratton

15. Birthplace Scotland

16. Informant Charles Crowe

Address 224 Walnut St. Westernport, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof Oct. 16 1940 (month) (day) (year)

Cemetery or crematory Pulas Cem.

Location Westernport, Md.

18. Funeral director Jay Beal Berry

Address Westernport, Md.

19. Oct. 15 1940 (Date rec'd by registrar) J. Baynebaker M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14th, 1940 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1940, to Oct 14, 1940

and that I last saw her alive on Oct 14th 1940

| Immediate cause of death | DURATION |
|---|---|
| Pneumonia Carcinoma | P |
| Due to Uterus | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Keener, M.D. M. D. or other

Address Westernport Md. Date signed 10-14-40

RECEIVED
NOV 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10218

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 912 Maryland Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Boy Davis

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife [illegible]

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/40

8. AGE: Years Stillborn | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Mr. Arlie Davis
13. Birthplace Elkins W. Va

MOTHER
14. Maiden name Miss Alice Liller
15. Birthplace Oldfield W. Va

16. Informant Mr. Arlie Davis

Address 912 Maryland ave. City.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct. 3, 1940
(month) (day) (year)

Cemetery or crematory Zion Memorial Cem.

Location Bedford Road

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Oct. 3, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1940, at 5 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2 1940, to Oct 2 1940, and that I last saw him alive on Stillborn 19

Immediate cause of death Intrauterine asphyxia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or other

Address 40 N. Liberty St. Date signed 10-2-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10219

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~All~~ 71 years

Hospital, institution, or street address where death occurred:
401 Oldtown Road

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 Oldtown Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Grant Davis

3.(b) Social Security Number None

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Cora Valentine

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 22, 1869

8. AGE: Years 71 Months 5 Days 20 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation Tinsmith

11. Industry or business N. & G. Taylor Tin Plate

FATHER
12. Name Francis T. Davis
13. Birthplace Cumberland Maryland

MOTHER
14. Maiden name Irene Zimmerly
15. Birthplace Cumberland, Maryland

16. Informant Cora Valentine Davis

Address 401 Oldtown Road

17. burial (Burial, cremation, or removal. Which?) Date thereof October 14, 1940 (month) (day) (year)

Cemetery or crematory Hillcrest

Location Baltimore Pike

18. Funeral director Louis Stein Inc.

Address Cumberland, Maryland

19. Oct 14, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 11 1940 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1938 to Oct 1 1940 and that I last saw him alive on Oct 11 19

Immediate cause of death Arteriosclerosis — DURATION 2 yr

Due to cerebral apoplexy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury No Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 33 Van Date signed 10/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

10220

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-D)

## CERTIFICATE OF DEATH

Reg. Diat. No. 14

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred: Ellerslie Rd.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No.: Ellerslie Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Susan Jane Dean

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife: —
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): March 26 1866

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 6 | 13 | ____ hrs. ____ min. |

9. Birthplace: Green Ridge Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home.
12. FATHER — Name: Lewis Dean
13. FATHER — Birthplace: Md.
14. MOTHER — Maiden name: Catherine Davis
15. MOTHER — Birthplace: Md
16. Informant: Mrs Elmer Deffinbaugh
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12 '40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.
18. Funeral director: Louis Stein Sons
Address: Cumberland.
19. Oct. 11, 1940 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct 9 1940, at 3.20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/8/40 19__ to 10/9/40 19__ and that I last saw h... alive on 10/9/40 19__

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of jaw | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John K. Kozma M.D. M. D. or other
Address: Cumberland Md Date signed 10/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10221

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186-a

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Days

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 16 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING
(If outside city or town limits, write RURAL and give nearest town)

Street No. SCOTCH HILL, Furnace St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** MR. ISRAEL DUCKWORTH

**3. (b) Social Security Number** None

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: WIDOWED

6.(b) Name of husband or wife: MARY Wiland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 16, 1849

**8. AGE:** Years 91 | Months 4 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace: MARYLAND, Fairview, Garrett Co.
(Town, county, and state)

10. Usual occupation: Retired Stonemason

11. Industry or business: Own Business

FATHER
12. Name: ~~Hiram~~ DUCKWORTH
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: Unknown - Fingerbone
15. Birthplace: Unknown

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cem

Location: Moscow, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Oct. 4, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION** 2:45

20. DATE OF DEATH: OCT. 4, 1940, at A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 18 1940, to OCT 4, 1940 and that I last saw him alive on Oct 3 1940

Immediate cause of death: Senility Cardiac failure

Due to: Fractured humerus; due to an accidental fall, on a cobble-stone road close to his home. C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Accident. Date of Sept. 17, 1940.

Where did injury occur? near his home. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Cobble-stone Road.

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: W. G. Gracie M. D. or other

Address: Cumberland Date signed Oct 4-40

DR. GRACIE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. M.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-C

## CERTIFICATE OF DEATH

10222

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 34 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: West Va. County: —

City or town: Kearns W Va (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war: —

**3. (a) FULL NAME** Daniel Eckard

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Lillie Eckard

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Feb 28 - 1880

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 7 | 19 | ... hrs. ... min. |

9. Birthplace: West Va (Town, county, and state)

10. Usual occupation: Fireman - Retired

11. Industry or business: R. Road - W. Md

MOTHER

12. Name: Jonathan Eckard

13. Birthplace: West Va

FATHER

14. Maiden name: Jemima Johnson

15. Birthplace: West Va

16. Informant: John Eckard

Address: Cumberland Md

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 20-40 (month) (day) (year)

Cemetery or crematory: Kearns, W Va

Location: Near Hendricks, W Va

18. Funeral director: U. L. Lemmerman

Address: Cumberland, Md.

19. Oct. 19 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-17-40 19... at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-30-40 19... to 10-17-40 19...

and that I last saw h... alive on 10-17-40 19...

Immediate cause of death: Carcinoma of Stomach — DURATION: 1 yr.

Due to: —

Due to: —

Other conditions: Hypertension & Pulmonary edema (Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Stomach Date of op. 10-14-40

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C. L. Lemmerman M. D. or other

Address: Cumberland, Md. Date signed: 10-18-40

RECEIVED
NOV 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Lulu Farraddy

Reg. Dist. No. 10223 9

**1. PLACE OF DEATH:**

County Allegany

City or town Frostburg, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution Miner's Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg, Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 152 Borrey St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Lulu Belle Farrady

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thos Farrady

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 21 1887

**8. AGE:** Years 53 Months 9 Days 23 If less than one day ___ hrs. ___ min.

9. Birthplace Midland, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Stevenson

13. Birthplace Midland, Md

MOTHER 14. Maiden name Belle Beaman

15. Birthplace Md.

16. Informant Mrs Grace Densmore

Address 221 Welsh Hill City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 17th 1940 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg Md

18. Funeral director Jacob Nafer

Address Frostburg, Md

19. Oct. 17 1940 (Date rec'd by registrar) Mrs. A. P. Walker Registrar

### MEDICAL CERTIFICATION 9.20

20. DATE OF DEATH October 14th., 1940, at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Fractured skull.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10/14/40

Where did injury occur? Near Frostburg, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury struck by auto Injured at work? no

23. SIGNATURE Lucius H. Corson, M.D. M. D. or other

Address Cumberland, Maryland. Date signed 10/15/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

## CERTIFICATE OF DEATH

10224

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred: 51 North Mechanic Street
How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 51 North Mechanic Street
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Mary Caroline Gatrall

**3.(b) Social Security Number** 214-05-5653

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife —
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.) Sept. 18, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | — | 16 | hrs. min. |

9. Birthplace Ryde, Isle of Wight, England (Town, county, and state)
10. Usual occupation Saleslady
11. Industry or business Shoe Store
FATHER 12. Name Woodman Gatrall
13. Birthplace Ryde, Isle of Wight, England
MOTHER 14. Maiden name Anne Lead Bentley
15. Birthplace Stonall, Birmingham, England
16. Informant Edward Charles Gatrall
Address 408 Hillcrest Ave., Newcastle, Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1940 (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Md.
18. Funeral director Wm. Eichhorn
Address Lonaconing, Md.
19. Oct. 5 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 4th 1940, at 4:12 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1940 to Oct 4 1940
and that I last saw h-- alive on Oct. 4 1940
Immediate cause of death Chronic Myocarditis — DURATION 9 mo
Due to Influenza
Due to —
Other conditions Carcinoma of uterus — 5 mo
(Include pregnancy within 3 months of death)
Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Charlotte B. Gardner M.D.
M. D. or other
Address Cumberland Md. Date signed 10-4-40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10225

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 326 Davidson St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 Davidson St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Mary Ella Hager

**3.(b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) ~~Single, married~~, widowed, ~~or divorced~~: widowed

6.(b) Name of husband ~~or wife~~ Charles D Hager

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov-3, 1862

**8. AGE:** Years 77 | Months 11 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name James M Hiteshew
13. Birthplace md.

MOTHER
14. Maiden name Virginia Geary
15. Birthplace Pa.

16. Informant Richard Hager
Address 326 Davidson St.

17. Burial
(Burial, ~~cremation, or removal. Which?~~)
Date thereof Oct 22, 1940
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland md

18. Funeral director Louis Stein Inc
Address Cumberland md

19. Oct. 21, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 19 1940, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1937, to Oct 19 1940 and that I last saw her alive on Oct 19 1940

Immediate cause of death: Arteriosclerosis — DURATION 3 yr

Due to: Valvular heart disease — 2 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E Owens
M. D. or other

Address 133 Va Ave Date signed Oct 21 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

T

S.E.B.

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10226

Reg. Dist. No. 8

**1. PLACE OF DEATH:**

County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, Institution, or street address where death occurred: Main Street

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war: —

**3. (a) FULL NAME:** Thomas Harrison Hamill

**3. (b) Social Security Number:** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6.(b) Name of ~~husband~~ or wife: Cora Geval

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1855.

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 2 | — | ..... hrs. ..... min. |

9. Birthplace: Frostburg, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation: Retired Civil Engineer

11. Industry or business: British Oil Co.

FATHER

12. Name: Charles F. Hamill

13. Birthplace: Unknown

MOTHER

14. Maiden name: Catherine Frost

15. Birthplace: Frostburg, Md.

16. Informant: Thos. H. Tyler

Address: Midland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 18th 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Glickhaus

Address: Lonaconing, Md.

19. Oct. 18 1940 (Date rec'd by registrar) Thos. H. Tyler Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 15 1940, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1940 to October 15 1940

and that I last saw him alive on October 10 1940

| | DURATION |
|---|---|
| Immediate cause of death: Coronary Occlusion | |
| Due to: | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M.D. (M. D. or other)

Address: Midland, Md Date signed: Oct. 17-1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10227

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 yrs

Hospital, institution, or street address where death occurred: 815 Schuyler Ave.

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 Schuyler Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war —

**3. (a) FULL NAME** Caroline Sophia Hartman

**3. (b) Social Security Number** —

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ernest Hartman

6.(c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) July 8 1856

**8. AGE:** Years 84 Months 3 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace Woodstock Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name Henry A Hensey
13. Birthplace Germany

MOTHER
14. Maiden name Sophia Raycob
15. Birthplace Germany

16. Informant Wm E. Hartman
Address Cumberland

17. Burial Date thereof Oct 24 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lukes Cem.

Location Cumberland

18. Funeral director Louis Stein Inc
Address Cumberland

19. Oct. 24 19 40 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10. 21. 1940 at 11 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-8-30 19..., to 10-21- 1940 and that I last saw her alive on 10. 19. 1940

Immediate cause of death: Arteriosclerosis — DURATION ?

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 10. 23. 40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-5)

## CERTIFICATE OF DEATH

10228

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
325 Cumberland Street
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 325 Cumberland Street
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Edith Hamilton Hendrickson

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Finley C. Hendrickson
6.(c) If alive, give age: 76yrs years
7. Birth date of deceased (mo., day, yr.): January 27, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 8 | 16 | ....hrs. ....min. |

9. Birthplace: Cumberland, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Levi Hamilton
13. Birthplace: Pa.
MOTHER 14. Maiden name: Melvina Wolford
15. Birthplace: Maryland
16. Informant: Finley C. Hendrickson
Address: 325 Cumberland Street
17. burial (Burial, cremation, or removal. Which?) Date thereof October 18, 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Baltimore Pike
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland
19. Oct 16 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1940; at 11 45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 14, 1940 to Oct. 15, 1940 and that I last saw her alive on Oct. 15, 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Liver | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Liver
Date of op.: Aug. 15, 1940
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clay B. Jarrett M. D. or other
Address: Cumberland Md. Date signed: Oct. 16, 1940.

RECEIVED
NOV 6 1940
BUREAU OF S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10229

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? residence 63 yrs
Hospital, Institution, or street address where death occurred:
178 Polk St.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 128 Polk Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Clara Loretta Hering

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: Frederick Hering
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): October 27, 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 11 | 24 | ...hrs. ...min. |

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Theodore Ogle
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Easter
15. Birthplace: Cumberland, Md.

16. Informant: John Hering
Address: Cumberland, Md

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: October 5, 1940
(month) (day) (year)
Cemetery or crematory: St. Luke's Cem. Kim
Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: 117 Fredrick St. Cumberland Md.

19. Oct. 4 1940 J. L. Franklin M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 1940, at 3:21 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1940, to Oct 3 1940
and that I last saw h[illegible] alive on Oct 2 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 24 hours |
| Due to: Chronic Nephritis | 5 yrs |
| Due to: Arteriosclerosis | 5 yrs |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. H. Koons M. D. or other
Address: Cumberland Md Date signed: 10/4/40

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

10230

WITHIN CORPORATE LIMITS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hospital Road
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Charles Calvin Ingram

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6.(b) Name of husband or wife: Anna Ingram
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Nov 14 1866

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 10 | 25 | hrs. min. |

9. Birthplace: Point of Rocks, Md.
(Town, county, and state)
10. Usual occupation: retired
11. Industry or business: tunnel foreman
FATHER 12. Name: Thomas Ingram
13. Birthplace: U.S.
MOTHER 14. Maiden name: Annie French
15. Birthplace: U.S.
16. Informant: Mrs Anna Ingram
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-12-1940 (month) (day) (year)
Cemetery or crematory: Point of Rocks
Location: Point of Rocks, Md.
18. Funeral director: M. R. & Etchison & Son
Address: Frederick, Md.
19. Oct. 9 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 9, 1940, at 10 15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1, 1940, to Oct. 9 1940
and that I last saw h.i.M. alive on Oct. 2 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 12 hrs. |
| Due to: C.V.R. disease with hypertension | 3 yrs. |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W E Gatteys M.D.
M. D. or other
Address: Frostburg, Md. Date signed 10/9/40

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-01)

## CERTIFICATE OF DEATH

10231

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 yrs.
Hospital, institution, or street address where death occurred:
507 Beall St.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 507 Beall St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Josephine Johnson.

**3.(b) Social Security Number** None.

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Wm. E. Johnson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 7 1863
8. AGE: Years: 77 Months: 2 Days: 5 If less than one day ..... hrs. ..... min.
9. Birthplace: Ellerslie, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Geo. A. Griffey
13. Birthplace: Bedford Pa.
MOTHER 14. Maiden name: Catherine Miller
15. Birthplace: Bedford Pa.
16. Informant: Walter A. Johnson.
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 14 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.
18. Funeral director: Louis Stein Inc.
Address: Cumberland.
19. Oct 14 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1940, at 4 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1940, to Oct 12 1940 and that I last saw h[illegible] alive on Oct 12 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral-Apoplexy. | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. M. Matthews M.D.
M. D. or other
Address 122 So Centre St. Date signed Oct 12 1940

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

10232

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
22 Potomac Street
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22 Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Martha Elizabeth Keller.

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Martin J. Keller
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 6 | 10 | hrs. min. |

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Alexander Elliott
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Susan Bowman
15. Birthplace: Pennsylvania

16. Informant: Martin J. Keller
Address: 22 Potomac Street

17. burial (Burial, cremation, or removal. Which?) Date thereof: Oct., 18, 1940 (month) (day) (year)
Cemetery or crematory: Cedar Grove
Location: Chambersburg, Pa.
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland

19. Oct. 16 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 1940, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1940, to October 15 1940 and that I last saw her alive on October 15 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 5 years. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. P. Franklin M.D. M. D. or other
Address: Cumberland Md. Date signed: 10/16/40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

10233

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in Hospital or Institution? Stillborn

**2. USUAL RESIDENCE (HOME) OF DECEASED**
(For newborn infants give residence of mother)
State Pa County Bedford
City or town Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war —

**3.(a) FULL NAME** Premature Girl Kennell

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Stillborn |

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1940

**8. AGE:** Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Ezra Kennell
13. Birthplace Garrett Pa

MOTHER
14. Maiden name Geraldine Minnich
15. Birthplace Hyndman Pa

16. Informant Ezra Kennell
Address Hyndman Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16 1940 (month) (day) (year)
Cemetery or crematory Hyndman Pa
Location Hyndman
18. Funeral director Jacob Zafer
Address Cumberland

19. Oct. 17 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1940, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15 1940, to 10/15 1940 and that I last saw h[illegible] alive on 10/15 1940

| Immediate cause of death | DURATION |
|---|---|
| Stillborn | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A. Topper M.D.
M. D. or other
Address Hyndman Pa Date signed 10/16/40

Dr Topper

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-D)

10234

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 10 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Penna. County: Allegheny

City or town: Braddock
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 308 Corey St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Mrs. Mary Kessler

**3.(b) Social Security Number:** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Anthony Kessler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 10th 1883

**8. AGE:** Years 57 | Months 9 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Braddock, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Schuster
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Anthony Kessler

Address: 308 Corey ave Braddock Pa.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 19, 1940 (month) (day) (year)

Cemetery or crematory: Braddock Catholic Cem.

Location: Braddock, Pa.

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md

19. Oct. 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 15 1940 at 1:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1940 to October 15 1940 and that I last saw her alive on October 15 1940

Immediate cause of death: Hemiplegia, right side — DURATION: 10 days

Due to: Cerebral hemorrhage. C.W.G.R. Duration: ten days.

Due to:

Other conditions: Uremia, Hypostatic Pneumonia — Two weeks, 4 days
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: ——

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Johnson Jr. M. D. or other

Address: Cumberland, Md Date signed: 10-15-40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

10235

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 5

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Triple Lakes

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Triple Lake - Near Cumberland
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** William H Kidwell

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, ~~widowed, or divorced~~: married

6.(b) Name of ~~husband~~ or wife: Alice Rebecca Murphy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 19, 1857

**8. AGE:** Years: 82 Months: 11 Days: 21 If less than one day ..... hrs. ..... min.

9. Birthplace: Keyser West Va
(Town, county, and state)

10. Usual occupation: Coal miner - " last worked

11. Industry or business: 22 years ago -

FATHER
12. Name: John Kidwell
13. Birthplace: West Va

MOTHER
14. Maiden name: Sulia True
15. Birthplace: West Va

16. Informant: Mrs Elizabeth Sayer
Address: Triple Lakes -

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov 2, 1940 (month) (day) (year)

Cemetery or crematory: Lease Cemetery

Location: near Cumberland, Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland - Md

19. 11/5, 1940 (Data rec'd by registrar) M G Vermutis Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 1940, at 11:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30. 1940, to Oct. 30 1940 and that I last saw him alive on October 30 1940

Immediate cause of death: Carcinoma stomach

DURATION: ?

Due to

Due to

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: ✓

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L J Kanich M. D. or other

Address: Cumberland Md Date signed 10-31-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 8 1940
BUREAU N. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10236

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 606 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Mr. John Kifer

**3.(b) Social Security Number:** Unknown

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6.(b) Name of husband or wife: Mary Twigg
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 9 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 5 | 13 | hrs. min. |

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: MRS. M. F. WELSH
Address: CUMBERLAND, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 40 (month) (day) (year)
Cemetery or crematory: Gilpintown Cem
Location: Gilpintown, Md
18. Funeral director: Louis Stein Inc.
Address: Cumberland
19. Oct. 24 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1940, at 12:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11 1940, to October 22 1940, and that I last saw h[illegible] alive on October 22 1940.

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 5 years |
| Due to: Hypertension | 4 years |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Cumberland, Md. Date signed: Oct. 22, 1940

DR. LANICH

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

10237

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (141-F)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Years
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 3 Day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 118 Decatur St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Kathleen Price Lannon

**3. (b) Social Security Number:** None

4. Sex: Female
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Paul Lannon
Sept. 11 1909 6.(c) If alive, give age 31 years
7. Birth date of deceased (mo., day, yr.): August 21, 1909

**8. AGE:** Years 31 Months 2 Days 6 If less than one day ..... hrs. ..... min.

9. Birthplace: West Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER
12. Name: Howard Price
13. Birthplace: W Va
MOTHER
14. Maiden name: Cynda Hill
15. Birthplace: W Va
16. Informant: Paul F. Lannon
Address: Cumb'd Md.
17. St Patrick's Burial, cremation, or removal. (Which?) Date thereof: Oct 30 1940 (month) (day) (year)
Cemetery or crematory: St Patricks Cem
Location: Cumb'd Md
18. Funeral director: J. L. Lemperer
Address: 202 Green St.
19. Oct. 29 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27th., 1940, at 5.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....
Immediate cause of death: Peritonitis
Criminal Abortion.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
DURATION

Major findings of operations: none
Date of op.
Autopsy results: Abortion. Peritonitis.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Linne H. Larson, M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed 10/28/40

Deputy Medical Examiner - Allegany Co.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
U. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10238

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 95 Bowery St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Baby Lashbaugh

**3. (b) Social Security Number:** —

**4. Sex:** Female

**5. Color or race:** White

**6. (a) Single, married, widowed, or divorced:** —

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

**7. Birth date of deceased (mo., day, yr.):** Oct. 29, 1940

**8. AGE:** Years | Months | Days | If less than one day: — hrs. 0 min.

**9. Birthplace:** Frostburg Md.
(Town, county, and state)

**10. Usual occupation:** —

**11. Industry or business:** —

FATHER
**12. Name:** Ralph C. Lashbaugh
**13. Birthplace:** Baltimore Md.

MOTHER
**14. Maiden name:** Mary Margaret Leasure
**15. Birthplace:** Lonaconing

**16. Informant:** Mrs. Ralph Lashbaugh
Address: Frostburg, Md.

**17.** Burial
(Burial, cremation, or removal. Which?) Date thereof Oct 29-1940 (month) (day) (year)
Cemetery or crematory: Old Lonaconing Cem.
Location: Lonaconing, Md.

**18. Funeral director:** Ralph C. Lashbaugh
Address: 95 Bowery St. Frostburg Md

**19.** Oct. 29 19 40 (Date rec'd by registrar) Mrs. A. R. Hafer (Registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH:** Oct. 29, 1940 19 —, at 3:30 A.M.

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from —19—, to —19—, and that I last saw h— alive on —19—.

| | DURATION |
|---|---|
| Immediate cause of death: Stillborn | |
| Due to: — | |
| Due to: — | |
| Other conditions: — | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

**22. VIOLENCE:** If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

**23. SIGNATURE:** N. E. Gatten M.D.
M. D. or other
Address: Frostburg, Md. Date signed 10/29/40

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10239

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 10 mo 6 day
Stay in this community (yrs., or mos., or days) same

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(If newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. La Vale Long R.D.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

**3. (a) FULL NAME** Robert Louis Law

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

B (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1939

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| | 10 | 6 | ____ hrs. ____ min. |

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Timothy A Law
13. Birthplace Pittsburg Pa.

MOTHER
14. Maiden name Virginia Long
15. Birthplace Cumberland Md.

16. Informant Virginia Long Law
Address La Vale

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9 1940 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Cumberland

18. Funeral director Jacob Lafer
Address Cumberland

19. Oct 8, 1940 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1940 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1939, to October 8 1940, and that I last saw h alive on October 7, 1940

Immediate cause of death: Bronchial Pneumonia — Duration 48 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F Johnson M.D.
M. D. or other
Address Cumberland Md Date signed 10-8-40

Dr Johnson Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-2) CD

10243

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Month 15 Days.
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 1 Mo 15 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: West Va County: Morgan
City or town: Paw Paw
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Myrtle Lawrence

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6.(b) Name of husband or wife: Floyd Lawrence
6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): Aug 10 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 2 | 1 | hrs. min. |

9. Birthplace: Woodrow Morgan Co W Va (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own Home

FATHER
12. Name: Harry Leach
13. Birthplace: Hampshire Co W Va

MOTHER
14. Maiden name: Mary Tidwell
15. Birthplace: Hampshire Co W Va

16. Informant: Floyd Lawrence
Address: Paw Paw W Va

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 14/40 (month) (day) (year)
Cemetery or crematory: Woodrow
Location: Woodrow W Va

18. Funeral director: H. D. Parks
Address: Paw Paw W Va

19. Oct. 14 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11 - 1940 19 at 9-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1940, to Oct 11 1940 and that I last saw her alive on Oct 11 da 1940

Immediate cause of death: Chronic Ulcerative Colitis with hemmorhage — DURATION: 18 Mos.
Due to:
Due to:
Other conditions: Anemia
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: J. T. Langston M. D. or other
Address: Cumberland Md Date signed: 10-12-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

10240

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 311 Springdale St.
Stay in hospital or inst. (yrs., or mos., or days) 5
Stay in this community (yrs., or mos., or days) 5 mo.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 311 Springdale St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Robert Michael Lisanti

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1940

8. AGE: Years 5 Months 7 Days If less than one day hrs. min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Giacinto Lisanti
13. Birthplace Cumberland Md

MOTHER 14. Maiden name Bessie Neal
15. Birthplace Bluefield W Va

16. Informant Giacinto Lisanti
Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24 40 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem.
Location Cumberland

18. Funeral director Louis Stein Inc.
Address Cumberland

19. Oct. 24 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 22 1940 at 8 00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 40 to Oct 22 1940 and that I last saw h alive on Oct 22 1940

| Immediate cause of death | Bronchopneumonia | DURATION 3 dy |
|---|---|---|
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 133 Va Date signed 10/24/40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10241

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 821 Shawnee Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louis Andrew Lovenstein

3.(b) Social Security Number None

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 23, 1925

8. AGE: Years 14 Months ~~10~~ 9 Days 15 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Md. (Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Hubert Lovenstein

13. Birthplace Terra Alta, W.Va.

MOTHER 14. Maiden name Clara A. Adams

15. Birthplace Westminister, Md.

16. Informant Hubert Lovenstein

Address Cumberland, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11, 1940 (month) (day) (year)

Cemetery or crematory St. Peter and Paul's

Location Cumberland, Maryland

18. Funeral director Louis Stein Inc.

Address Cumberland, Maryland

19. Oct. 10, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1940, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1940 to Oct. 8, 1940 and that I last saw him alive on Oct. 8, 1940

Immediate cause of death Shock due to injuries

Due to Fall 100 feet

Due to

Other conditions Comp. fracture l. leg; Convulsion - Mangled l. leg (Include pregnancy within 3 months of death)

DURATION 2 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-6-40

Where did injury occur? Cumberland (City or town) Alley (County) Md. (State) Narrows Park

Injured at home, farm, industry, public place (where?) Lovers' Leap

Means of injury Fell from cliff. Injured at work?

23. SIGNATURE C. C. Rimmerman M.D. M. D. or other

Address 105 S. Centre St. Cumberland Md. Date signed 10-9-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10244

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town SHALLMAR (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** IRMA JEAN LUCAS

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | INFANT |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~AUG~~ MAR. 31 - 1940

**8. AGE:** Years | Months 26 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name WILLIAM HENRY Lucas

13. Birthplace MARYLAND

MOTHER 14. Maiden name BERTHA IDAMAN

15. Birthplace WEST VIRGINIA

16. Informant W. H. LUCAS

Address SHALLMAR, MD.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10/19/40 (month) (day) (year)

Cemetery or crematory Rehobath Cemetery

Location Schell WVa

18. Funeral director O. F. Sharpless

Address Blaine WVa

19. Oct. 18 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. VAV ORMER

**MEDICAL CERTIFICATION**

20. DATE OF DEATH OCTOBER 17, 1940 19 ..... at 3:15 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9-40 19 ..... to Oct. 17 1940

and that I last saw her alive on Oct - 16 - 40 19

Immediate cause of death: Chronic entero-colitis — DURATION: 2 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm Alfred Van Ormer M. D. or other

Address Cumberland Date signed 10-13-40

VS A15 (T) (I) (M) (C)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44-E

## CERTIFICATE OF DEATH

10245

Reg. Dist. No. 6

**1. PLACE OF DEATH:**
County: Allegany
City or town: Franklin (uncorporated)
(If outside city or town limits, write RURAL and give nearest town). near Westernport, Md.
How long in above place of death? 1 Yr.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Franklin (unincorporatrd)
(If outside city or town limits, write RURAL and give nearest town) near Westernport, Md.
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Ettie Catherine Mackley

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife:
6.(c) If wife, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 21, 1937.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 2 | 4 | hrs. min. |

9. Birthplace: (Near) Keyser-Mineral-", Va.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Ilce R. Mackley
13. Birthplace: Elk Garden, W.Va.
MOTHER 14. Maiden name: Grace Wetzel
15. Birthplace: Petersburg, W.Va.
16. Informant: Ilce R. Mackley
Address: Franklin, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 27, 1940 (month) (day) (year)
Cemetery or crematory: Philos
Location: "esternport, Md
18. Funeral director: Ellsworth S. Boal.
Address: Westernport. Md.
19. Oct. 27 1940 (Date rec'd by registrar) J. Raymbaker M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 25 1940, at 10.15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1940, to Oct 23 1940 and that I last saw her alive on Oct 23 1940

Immediate cause of death: Pseudoleukemia (Hodgkins Disease) — DURATION: 18 mo.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. A. Courrier M.D. M. D. or other
Address: Keyser W. Va Date signed: 10-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
FBI

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10242

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 400 York Place

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 45 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 400 York Place
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

**3. (a) FULL NAME** Margaret Mattingly

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1885

**8. AGE:** Years 65 | Months | Days 24 | If less than one day hrs. min.

9. Birthplace Cooks Mills, Bedford Co., Pa
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home.

FATHER
12. Name James T. Mattingly
13. Birthplace Cooks Mills Pa

MOTHER
14. Maiden name Rosalia Topper
15. Birthplace New Baltimore, Pa

16. Informant Mary Martin

Address 431 Arch St - Cumberland, Md.

17. Burial Date thereof Oct 12, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peters + Pauls

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19. Oct. 12, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr. M. E. B. Owens

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 10 1940, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1940, to Oct 10 1940, and that I last saw her alive on Oct 10 1940

Immediate cause of death Arteriosclerosis

Due to My Occupation

Due to Diabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2 yrs

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. E. B. Owens M. D. or other

Address 138 Van Date signed Oct 1/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

10246

# CERTIFICATE OF DEATH

Reg. Dist. No. 7

**1. PLACE OF DEATH:**

County Allegany County

City or town Frostburg Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 118 McCulloh St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 118 McCulloh

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** ELLEN TERESA McDADE

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | widow |

6 (b) Name of husband or wife Charles McDade Sr. Deceased

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) not known

**8. AGE:** Years 74 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Wales, British Isles. (Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business none

FATHER 12. Name Daniel Begley

13. Birthplace Wales - British Isles.

MOTHER 14. Maiden name Not Known

15. Birthplace

16. Informant Mrs Charles Sullivan

Address 86 Hurlburt ave., Akron Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12, 1940 (month) (day) (year)

Cemetery or crematory St. Mecheals Cemetary

Location Frostburg Md.

18. Funeral director Jacob Hofer

Address Frostburg Md

19. Oct. 11th 1940 (Date rec'd by registrar) Mrs. A.R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1940, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to Oct 9 1940, and that I last saw her alive on Oct 8 1940.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations no

Of autopsy no

DURATION: General no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. O. McCane Jr. M.D. M. D. of other

Address Frostburg Md Date signed Oct 9 1940

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 2 1940
BUREAU V. S.

Outside of City limits

10247

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Woodlawn LaVale Rt #1
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Woodlawn, LaVale Rt #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Caroline Merritt

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6.(b) Name of husband or wife: Arthur Lee Merritt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 7 | 9 | hrs. min. |

9. Birthplace: Connelsville Pa
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own House

FATHER
12. Name: Christian Miller
13. Birthplace: Elsace Lorane, France

MOTHER
14. Maiden name: Caroline Grimer
15. Birthplace: Elsace Lorane France

16. Informant: Mrs E Allan Reith
Address: Woodlawn LaVale City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1940 (month) (day) (year)
Cemetery or crematory: Hill Crest
Location: Cumberland Md

18. Funeral director: William H Kight
Address: Cumberland Md

19. Oct 14 1940 (Data rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 11/40 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10/40 19..... to Oct. 11 19 40
and that I last saw h[illegible] alive on Oct. 10 19 40

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 18 hrs |
| Due to: Not determined — | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin M. D. or other
Address 41 - Queen St. Cumberland Date signed Oct. 11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V.S.

10248

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: Eckhart, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Joseph Michaels

**3. (b) Social Security Number** None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Annie Michaels

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 8, 1860

**8. AGE:** Years: 80 Months: 4 Days: 27 If less than one day ... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Harmon Michaels
13. Birthplace: Germany

MOTHER
14. Maiden name: unknown
15. Birthplace: Germany

16. Informant: Mrs. Annie Michaels
Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9, 1940 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Daiest
Address: Frostburg Md.

19. Oct. 7th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 1940, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1940, to Oct. 6 1940 and that I last saw him alive on Oct. 1 1940.

Immediate cause of death: Carcinoma of bladder — DURATION: 1 yr.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: N. E. Gattens M.D. M. D. or other

Address: Frostburg, Md. Date signed: Oct. 7, 1940

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10249

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dropped dead on street

Hospital, Institution, or street address where death occurred: Lamont St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED**

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 160 Polk St

(If rural, give LOCATION)

2.(a) If veteran, name war No

**3. (a) FULL NAME** John George Nimick

**3. (b) Social Security Number** None

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife Lillian McKenzie Nimick

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Mar 27, 1877

**8. AGE:** Years 69 Months 6 Days 17 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual occupation Labored

11. Industry or business City of Cumberland

FATHER 12. Name John Nimick

13. Birthplace Bohemia

MOTHER 14. Maiden name Mary Kraler

15. Birthplace Bohemia

16. Informant John F. Nimick

Address Ellerslie Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct 17 40 (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md

18. Funeral director Jacob Hafer

Address Cumberland, Md

19. Oct. 16 19 40 J. P. Franklin, M. D. Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 14th 1940, at 2.50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce H. Corson, M. D. M. D. or other

Address Cumberland, Md. Date signed 10-15-40

Deputy Medical Examiner - Allegany Co.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T)

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10250

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 925 Grand Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Stillborn Baby Boy Moyer

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W. | Infant |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Still birth Oct 5, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Lester Lee Moyer

13. Birthplace Elkins, West Virginia

MOTHER 14. Maiden name Emma Jane Moyer

15. Birthplace Meyers Lake, Penn.

16. Informant Lester Moyer

Address 925 Grand Ave, Cumberland, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct 8, 1940 (month) (day) (year)

Cemetery or crematory Hafer's crematory

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland, Md

19. Oct. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1940, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5, 1940, to Oct. 5, 1940, and that I last saw h[illegible] alive on Stillborn, 19

| Immediate cause of death | DURATION |
|---|---|
| Syphilis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause fo which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arthur J. Jones M. D.
M. D. or other
Address 40 N. Liberty St. Date signed 10-7-40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B

## CERTIFICATE OF DEATH

10251

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: R.F.D. #5 Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Florence Miranda Shipley Niner

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

B.(b) Name of husband or wife: Lewis Niner

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): July 18 1870

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 | 13 | hrs. min. |

9. Birthplace: Carroll Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: George Shipley

13. Birthplace: Carroll Co Md

MOTHER 14. Maiden name: Louisa Pickett

15. Birthplace: Carroll Co, Md

16. Informant: John H. Niner

Address: R.F.D. #5 Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3 1940 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: [illegible]

Address: 1230 Baltimore Ave.

19. Nov 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 31, 1940, at 6.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29, 1940, to Oct 31, 1940 and that I last saw h[illegible] alive on Oct 29, 1940

| Immediate cause of death | DURATION |
|---|---|
| Organic Heart Disease | 4 yrs |
| Chronic Endocarditis | 4 yrs |
| Due to Chronic Nephritis | 4 yrs |
| Due to Dropsy | 1 yr |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. H. Koon M. D. or other

Address: Cumberland Md Date signed 10/31/40

RECEIVED
NOV 6 1940

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-F)

## CERTIFICATE OF DEATH

10252

Reg. Dist. No. 8

VS A45 (T) (I) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**

County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 2 yrs

Hospital, institution, or street address where death occurred: Douglas Avenue

How long in hospital or institution? 2

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Douglas Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: /

**3. (a) FULL NAME:** Ida E. Cook Orr

**3. (b) Social Security Number:** c

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: William A Orr

6.(c) If alive, give age: c years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1864

8. AGE: Years: 76 | Months: 7 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Hellersburg Pa (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER 12. Name: Solomon Cook

13. Birthplace: Hellersburg, Pa

MOTHER 14. Maiden name: Martha Jane Rathbun

15. Birthplace: Hagerstown, Pa.

16. Informant: Mrs. Margaret Beck

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Oct. 13, 1940 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Oct 13 1940 (Date rec'd by registrar) E. Don Tyler Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 11 1940 at 3 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct. 9 1940, to Oct. 11 1940

and that I last saw h[illegible] alive on Oct. 11 - 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Cardiac Dilation | |
| Sudden Death - | |
| Due to: Hyper Thyroid Con. | 10 yrs |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Don Tyler M.D.

M. D. or other

Address: Lonaconing, Md. Date signed: Oct 13 1940

RECEIVED
NOV 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

10253

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Eckhart
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Englestown, Eckhart
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 5 months 6 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany
City or town Eckhart Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Englestown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** James Salem Perkins

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Child |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1940

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| | 8 | 6 | hrs. min. |

9. Birthplace Eckhart Allegany Md
(Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Lloyd E. Perkins
13. Birthplace National, Md

MOTHER
14. Maiden name Rose Muir
15. Birthplace Midland, Md

16. Informant Lloyd E. Perkins
Address Eckhart, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30, 1940 (month) (day) (year)
Cemetery or crematory Eckhart
Location Eckhart, Md

18. Funeral director Jacob Hafer
Address Frostburg, Md

19. Oct. 30 1940 (Date rec'd by registrar) mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1940, at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 1940, to Oct 27 1940, and that I last saw him alive on Oct 27 1940

Immediate cause of death Bronchial Pneumonia — DURATION 2 Days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Kane Jr. M.D. M. D. or other

Address Frostburg, Md Date signed Oct 28/40

RECEIVED
NOV 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

10254

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town KEIFER (MAIL TO PAW PAW W.VA
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** HOGBIN, BABY PHYLIS

**3. (b) Social Security Number**

4. Sex: FEMALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 19, 1940

**8. AGE:** Years | Months | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name WILLIAM A. HOGBIN
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name WILDA CHILDERS
15. Birthplace WEST VIRGINIA

16. Informant WILLIAM H OGBIN
Address KEIFER, MD.

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof Oct. 18, 1940 (month) (day) (year)

Cemetery or crematory Woodrow Cem.

Location Woodrow, W.Va.

18. Funeral director W D Park
Address Paw Paw W.Va

19. Nov. 1 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DDR. ELIASON

**MEDICAL CERTIFICATION**

20. DATE OF DEATH OCTOBER 16, 1940 19 ..... at 5;10 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-13-40 19 ..... to 10-16-40 19 ..... and that I last saw her alive on 10-15-40 19 .....

Immediate cause of death ~~Congenital~~ Bronchial Pneumonia — DURATION 1 week

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please noderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Oem
M. D. or other

Address Cumberland, Md. Date signed 10-16-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10255

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** MRS. MARY BAFARO PRATT

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | WIDOWED |

6.(b) Name of husband or wife THOMAS PRATT
6.(c) If alive, give age ~~94~~ years

7. Birth date of deceased (mo., day, yr.) August 30, 1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 1 | 19 | hrs. min. |

9. Birthplace ITALY
(Town, county, and state)
10. Usual occupation AT HOME
11. Industry or business

FATHER
12. Name ANTHONY BAFARO
13. Birthplace ITALY

MOTHER
14. Maiden name Rose ——
15. Birthplace Italy

16. Informant O. F. Shappless
Address Blaine

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 21/40 (month) (day) (year)
Cemetery or crematory Kalbaugh Cemetery
Location Elk Garden W Va
18. Funeral director O. F. Shappless
Address Blaine W Va

19. Oct. 21 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 19, 1940 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 14, 1940, to OCT. 19, 1940 and that I last saw her alive on OCT. 19, 1940

| Immediate cause of death | DURATION |
|---|---|
| Diabetes Mellitus | |
| Generalized Arteriosclerosis | |
| Due to Coronary Thrombosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clark E. Durrett M. D. or other
Address Cumberland. Date signed Oct. 19, 1940

DR. DURRETT

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1454

RECEIVED
NOV 6 1940
BUREAU V. S.

VS A15 (M) (I) (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(92-2)

10256

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**

County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. Beechwood

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Marge Pearl Preston

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: James A. Preston

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.): Mar. 24, 1891

**8. AGE:** Years 49 | Months 6 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: Barton-Allegany-Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: own home

FATHER

12. Name: James W. Dye

13. Birthplace: Lonaconing, Md.

MOTHER

14. Maiden name: Margaret Fough

15. Birthplace: Barton, Md.

16. Informant: James A. Preston

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 14, 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Moscow, Md.

18. Funeral director: Ellsworth. S. Boal.

Address: Westernport, Md.

19. Oct. 13 1940 (Date rec'd by registrar) E. Ora Taylor Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1940, at 12 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1935 ~~19~~, to Oct. 11 1940

and that I last saw her alive on Oct 11 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic myocarditis | 8 yrs |
| Due to Mitral insufficiency | |
| Due to | |
| Other conditions Acute Cholecystitis | 4 days |

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE P E Berry M.D. M. D. or other

Address Piedmont W.Va. Date signed Oct. 12-40

RECEIVED
NOV 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15?)

10257

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

**1. PLACE OF DEATH:**
County: Allegany
City or town: Westernport Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ hours
Hospital, institution, or street address where death occurred:
The Reeves Clinic
How long in hospital or institution? 1½ hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: W Va County: Monroe
City or town: Shaw
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3. (a) FULL NAME** Premature PRITTS

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 1 hrs. 30 min. |

9. Birthplace: Westernport, Allegany Co., Maryland
(Town, county, and state)
10. Usual occupation:
11. Industry or business

FATHER
12. Name: Earl Franklin Pritts
13. Birthplace: Shamerset Co. Pa.

MOTHER
14. Maiden name: Lyda Viola Brant
15. Birthplace: Summerset Co., Pa.

16. Informant: Mrs. Pritts
Address: Shaw, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5, 1940 (month) (day) (year)
Cemetery or crematory: Cross
Location: Cross, W. Va
18. Funeral director: Barney Smith
Address: Shaw, W. Va

19. Oct. 5 1940 (Date rec'd by registrar) J. Raymond Baker M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-4 1940 at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4- 1940 to 10-4 1940 and that I last saw h- alive on 10-4- 1940

| Immediate cause of death | DURATION |
|---|---|
| Prematurity | |
| Due to (4 months) | |
| Due to Cause Not Known | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C W Reeves M.D. M. D. or other
Address: Westernport Md Date signed: 10-4-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 5 1940
[illegible]

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

10258

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred: 101 Springdale St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 Springdale St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** George Price

**3. (b) Social Security Number** None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Bessie Wishmeyer

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov 16 1877

**8. AGE:** Years 62 | Months 11 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace Cincinnati Ohio
(Town, county, and state)

10. Usual occupation Tin worker

11. Industry or business Retired 5 yrs

FATHER
12. Name — Price
13. Birthplace England

MOTHER
14. Maiden name Sarah Ball
15. Birthplace England

16. Informant Mrs Bessie Price

Address Cumberland

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct 30 40
(month) (day) (year)

Cemetery or crematory St Lukes Cem

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct. 30 19 40 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 19 40, at 11:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15, 19 35, to Oct. 27, 19 40 and that I last saw him alive on Oct. 27, 19 40

Immediate cause of death Coronary Thrombosis — DURATION 10/29/40

Due to Chronic Myocarditis Auricular Fibrillation — 1935

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett M. D. or other

Address Cumberland Date signed Oct. 28, 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T)

RECEIVED
NOV 6 1940

WITHIN CORPORATE LIMITS.

10259

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K4C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 647 Bedford St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 647 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Veda Rawlings

**3.(b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 22, 1903

8. AGE: Years 37 | Months 9 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace: Deer Park, Garrett, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Grimm
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lucy Baldwin
15. Birthplace: Maryland

16. Informant: Mr. Edward Grimm
Address: Deer Park, Md.

17. Burial (Burial, cremation, or removal/Which?) Date thereof: Nov. 3, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem

Location: Cumberland, Md

18. Funeral director: V. L. Lempereur
Address: Cumberland, Md.

19. Nov. 2 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 31st., 1940 about at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Suicide by gunshot (38 Cal. lead bullet)

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: suicide Date of: 10-31-40

Where did injury occur? Cumberland, Allegany, Maryland.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: gun shot Injured at work? no

23. SIGNATURE: Pinnie H. Conon, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 11/1/40

Deputy Medical Examiner - Allegany Co.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940

WITHIN CORPORATE LIMITS

10260

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 12 Hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 82 Bowery St. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** OSBORN CLAYTON RICHARDSON

**3.(b) Social Security Number:** 217-07-3401

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: MARRIED

6.(b) Name of husband or wife: EMMA VIOLET RICHARDSON

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.): JUNE 8, 1891

**8. AGE:** Years 49 | Months 4 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany Maryland (Town, county, and state)

10. Usual occupation: Laborer + Miner

11. Industry or business: W. P. A.

FATHER: 12. Name: James Henry Richardson

13. Birthplace: England

MOTHER: 14. Maiden name: Mary Ann Reese

15. Birthplace: Wales

16. Informant: Emma Violet Richardson

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetary

Location: Frostburg Md.

18. Funeral director: Jacob Hofer

Address: Frostburg, Md.

19. Oct. 21 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1940, to Oct. 19 1940.

and that I last saw him alive on October 19 1940

Immediate cause of death: Uremia — DURATION: 2 days

Due to: ~~Chronic~~ Acute nephritis — 2 months

Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. E. Gattens M.D. M. D. or other

Address: Frostburg, Md. Date signed 10/21/40.

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10261

Reg. Diat. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: allegany

City or town: Barrelville Mt Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Whole life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Barrelville - Mt Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Robert Eugene Riggleman

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | single |

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 28 - 1937

**8. AGE:** Years: 3 | Months: 4 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mt Savage Md
(Town, county and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Ellsworth L Riggleman

13. Birthplace: Westernport Md.

MOTHER — 14. Maiden name: Freda F. Weatherholt

15. Birthplace: Oldfields W. Va.

16. Informant: Ellsworth Riggleman

Address: Barrelville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 2 1940 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Mt Savage Md

18. Funeral director: J. J. Deirst

Address: Frostburg Md

19. Oct 31 1940 (Date rec'd by registrar) A J Bostetter M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct 31 1940, at 1.15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1940 to Oct 31 1940 and that I last saw him alive on Oct 30 1940

Immediate cause of death: Poliomyelitis — DURATION: 3 Days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A J Bostetter M.D. M.D. or other

Address: Mt Savage Md Date signed: Oct 31 40

RECEIVED
NOV 2 1940
BUREAU OF S.

10262

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: National (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: National, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** James Russel Ritchie

**3.(b) Social Security Number:** None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife

B.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 20 - 1940

**8. AGE:** Years: 0 Months: 3 Days: 0 If less than one day ... hrs. ... min.

9. Birthplace: Frostburg - Alleg - Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Roy Ritchie
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Eleanor Yantz
15. Birthplace: National, Md.

16. Informant: Roy Ritchie
Address: National, Md.

17. Burial Md (Burial, cremation, or removal. Which?) Date thereof: Oct 22-1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. Oct. 22 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 1940, at 9:20 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Broncho Pneumonia

Child died not having been seen by Doctor. Was dead before doctor called

Due to: From discription of case should be

Other conditions: classified as Broncho Pneumonia (Include pregnancy within 3 months of death)

DURATION: 2 Day

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: W. McLane Jr. M.D. (M. D. or other)

Address: Frostburg Md Date signed: Oct 21 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40-E)

# CERTIFICATE OF DEATH

10263

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

**1. PLACE OF DEATH:**

County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

**3.(a) FULL NAME:** Jasper Wilson Robinette

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Mary Chaney Robinette

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): Dec 16, 1854

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 10 | 1 | hrs. min. |

9. Birthplace: Flintstone, Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: George E.W. Robinette

13. Birthplace: Flintstone, Md.

MOTHER

14. Maiden name: Elizabeth Lashley

15. Birthplace: Flintstone, Md.

16. Informant: Pluma R. Wilson

Address: Flintstone, Md.

17. Interment Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 19, 1940 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland

18. Funeral director: Sands Hotle

Address: Cumberland, Md.

19. Oct 19 1940 (Date rec'd by registrar) D. Bennett Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 17, 1940 at 1.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1940, to Oct. 17 1940 and that I last saw him alive on October 13 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of cecum | 8 mo. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Watson, M.D. M. D. or other

Address: Little Orleans, Md. Date signed: Oct. 17, 1940.

RECEIVED
NOV 4 1946
U. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10264

Reg. Dist. No. 4

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 years

Hospital, institution, or street address where death occurred: 412 Chestnut St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 412 Chestnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Mary Hafer Ruehl

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Widowed |

6.(b) Name of husband or wife: Henry Ruehl

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 16, 1856

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 7 | 29 | ..... hrs. ..... min. |

9. Birthplace: New-Morschen, Germany. (Town, county, and state)

10. Usual occupation: House work.

11. Industry or business: At Home

FATHER 12. Name: Otto Hafer.

13. Birthplace: Germany

MOTHER 14. Maiden name: Annie Berg

15. Birthplace: Germany.

16. Informant: Anna Kline

Address: 412 Chestnut St Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 17, 1940 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Cumberland Md.

18. Funeral director: Jacob Hafer

Address: Cumberland Md.

19. Oct. 17 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr Reynolds

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1940, at 11 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 14 1940, to Oct 14 1940 and that I last saw her alive on Oct 14 /40 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Liver. | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dwight Reynolds M.D. M. D. or other

Address: Cumberland Md. Date signed: Oct 16/40

RECEIVED
NOV 6 1940
BUREAU V. S

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

## CERTIFICATE OF DEATH

10265

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Yrs.
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 212 PULASKI ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** MR. SAMUEL RUPP

**3. (b) Social Security Number** 705-09-3512

| 4. Sex | 5. Color or race | 5.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | Widowed. |

6.(b) Name of husband or wife Hamill White
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JAN. 17 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 8 | 24 | ..... hrs. ..... min. |

9. Birthplace PENNA. (Town, county, and state)
10. Usual occupation FOREMAN @ B.&O.R.R.
11. Industry or business

FATHER
12. Name SAMUEL RUPP
13. Birthplace PENNA.

MOTHER
14. Maiden name WISE, ANNA
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13 '40 (month) (day) (year)
Cemetery or crematory Rose Memorial Cem.
Location near Cumberland.

18. Funeral director Louis Stein Sons
Address Cumberland.

19. Oct 12 1940 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** 11:58

20. DATE OF DEATH OCT 11, 1940 at AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT 5, 1940, to OCT 11 1940 and that I last saw h... alive on OCT 11, 1940

| | DURATION |
|---|---|
| Immediate cause of death Carcinoma of Pancreas | 1 Year |
| Due to ? | |
| Due to | |
| Other conditions Metastasis to Liver | ? |

(Include pregnancy within 3 months of death)

Major findings of operations 2 Large masses in Pancreas - Nodules in liver Date of op. Oct. 10, '40.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W Royce Hodges M. D. or other
Address Cumberland, Md Date signed 10/11/40

DR. HODGES

RECEIVED
NOV 6 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

19266

(107)

**1. PLACE OF DEATH**

County ALLEGANY Registration Dist. No.

Village or City FROSTBURG MARYLAND No. MINERS HOSPITAL St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** JAMES MARSHALL SAURBAUGH Veteran of World War

SOCIAL SECURITY NO. 159-12-8899

(a) Residence: No. SPRING St., Ward.
(Usual place of abode)
If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| MALE | WHITE | DIVORCED |

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of NETTIE SAURBAUGH

6. DATE OF BIRTH (month, day, and year) Oct. 21, 1894

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 45 | 11 | 18 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. ELECTRICIAN

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. P. W. A

10. Date deceased last worked at this occupation (month and year) SEPT. 27, 1940

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) FROSTBURG MARYLAND
(State or country)

FATHER

13. NAME JOHN WILLIAM SAURBAUGH

14. BIRTHPLACE (city or town) FROSTBURG MARYLAND
(State or country)

MOTHER

15. MAIDEN NAME ELLA VIRGINIA CHAPMAN

16. BIRTHPLACE (city or town) DORTSVILLE VA.
(State or country)

17. INFORMANT JOHN WILLIAM SAURBAUGH
(Address) 7015½ CHURCHLAND ST. P.O. H. PR. E.E.

18. BURIAL, CREMATION, OR REMOVAL
Place [illegible] CEMETARY Date OCT. 6, 1940

19. UNDERTAKER Jacob Hafer
(Address) Frostburg Md.

20. FILED Oct. 6, 1940 Mrs. A. R. Walker
Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Oct (Month) 3 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1940 to Oct 3, 1940
I last saw him alive on Oct 3, 1940 death is said to have occurred on the date stated above, at 8:45 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Broncho pneumonia | |
| | |
| | |
| | |
| | |

Other **Contributory Causes** of importance:
Hellenium Tremors

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) A. M. Eccles M. D.
(Address) Ed. Dr. main St

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.* Frostburg Md.

M

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

RECEIVED
OCT 9 1940
BUREAU V. S.

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**

Outside of City Limits

Birth Reg Oct 25

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

10267

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred: R7D#3 Cumberland Md

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md R7D #3
(If outside city or town limits, write RURAL and give nearest town)

Street No. R7D#3. Cumberland Md
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Charlotte Jean Saville

**3. (b) Social Security Number:** None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct ~~26~~ 25 - 1940

**8. AGE:** Years | Months | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace: Cumberland Md Allegany Co
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Chas Sloan Saville
13. Birthplace: Hoy W Va Hampshire Co

MOTHER
14. Maiden name: Dorthy Manley
15. Birthplace: Altoona Pa

16. Informant: Chas Sloan Saville
Address: R7D#3 Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 27/40 (month) (day) (year)

Cemetery or crematory: Home Cemetery

Location: R7D#3 Cumberland Md

18. Funeral director: William H. Kight
Address: Cumberland Md

19. Oct 27 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1940 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1940 to Oct 26 1940 and that I last saw her alive on Oct 25 1940

Immediate cause of death: Premature birth — DURATION: 6 mos foetus

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: R. N. Trevaskis, M.D. M. D. or other

Address: Cumberland, Md Date signed: Oct 26-'40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of
City Limits

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

10268

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 20 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 510 Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Mrs. Margaret Elizabeth Schade

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Mr. Louis Schade
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 30, 1876

8. AGE: Years: 64 | Months: 4 | Days: 29 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Conrad Miller
13. Birthplace: Maryland

MOTHER
14. Maiden name: Barbara Krull
15. Birthplace: Maryland

16. Informant: Louis Schade
Address: Cumberland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Nov 1 40
(month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Nov. 1, 1940 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1940, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 9, 1940 to Oct. 29, 1940 and that I last saw h[illegible] alive on 10-29-1940

| Immediate cause of death | DURATION |
|---|---|
| Diabetes Mellitus | Many yrs. |
| Chronic Nephritis | 4 4 |
| Due to: Hypertension | |
| Uremia | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. J. Williams M.D. or other
Address: Cumberland Date signed 10/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
U. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160-a

## CERTIFICATE OF DEATH

10269

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 724 N. CENTRE STREET

(If rural, give LOCATION)

2.(a) If veteran, name war —

**3. (a) FULL NAME**

WILLIAM SCHAUWECKER (BABY)

**3. (b) Social Security Number**

None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | White | SINGLE |

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 7 1940

8. AGE: Years | Months | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER — 12. Name SCHAUWECKER, ROBERT

13. Birthplace MARYLAND

MOTHER — 14. Maiden name GRACE LEE DAWSON

15. Birthplace MARYLAND

16. Informant Robert Schauwecker

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 1940 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein & Son

Address Cumberland

19. Oct. 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION** 1:04 PM

20. DATE OF DEATH OCTOBER 14 1940 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-13-40 1940 to 10-14-40 1940 and that I last saw h... alive on 10-14-40 1940

| Immediate cause of death | DURATION |
|---|---|
| Intra-Cranial Hemorrhage from birth injury | 10 days |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Alfred Van Ormer M. D. or other

Address Cumberland Md Date signed 10-15-40

DR. VAN ORMER

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

10270

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 6 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 941 Gay St

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME** Harold Edmund Shaw

**3.(b) Social Security Number** 205-14-2329

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Edna Lambert Shaw

6.(c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.): July 17, 1915

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 3 | 5 | ... hrs. ... min. |

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Laborer Shops

11. Industry or business: B & O. R. R.

FATHER

12. Name: Louis Cass Shaw

13. Birthplace: Cumberland, Md

MOTHER

14. Maiden name: Loula Keys

15. Birthplace: Barton, Md.

16. Informant: Loula Shaw

Address: 941 Gay St. Cumberland Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Oct. 24 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Jacob Lefer

Address: Cumberland, Md.

19. Oct. 24 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-22 19 40, at 1.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/27/40 19.., to 10/22/40 19..

and that I last saw h.. alive on 10/22/40 19..

| Immediate cause of death | DURATION |
|---|---|
| Bronchopneumonia | |
| Due to | |
| Due to | |
| Other conditions: Chronic alcoholism | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John K Rozzell M.D. M. D. or other

Address: Cumberland Md Date signed: 10/23/40

RECEIVED
NOV 6 1940
BUREAU V. S.

Outside of City Limits

10271

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c) CNO

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegheny
City or town Near Cumberland Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State W. Va. County Morgan
City or town Paw Paw Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Edward H. Sipes
3. (b) Social Security Number None

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife ✓
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4 - 27 - 1890
8. AGE: Years 50 Months 5 Days 8 If less than one day hrs. min.
9. Birthplace Washington Co Pa (Town, county, and state)
10. Usual occupation Common Laborer
11. Industry or business
FATHER 12. Name Daniel Sipes
13. Birthplace Pa
MOTHER 14. Maiden name Marie Alice Divibliss
15. Birthplace Gt Cacapon Wva
16. Informant George Sipes
Address Paw Paw Wva
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/8/40 (month) (day) (year)
Cemetery or crematory Woodrow
Location Woodrow Wva
18. Funeral director W D Parks
Address Paw Paw Wva
19. Oct. 8, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th., 1940, about 10.50 at P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .
Immediate cause of death Comminuted fracture skull, right temporal region.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations none
Of autopsy none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 10/5/40
Where did injury occur? Paw Paw, (City or town) ------- (County) West Va. (State)
Injured at home, farm, industry, public place (where?) highway
Means of injury struck by auto. Injured at work? no

23. SIGNATURE Linne H. Corson, M.D. M. D. or other
Address Cumberland, Md. Date signed 10/7/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

## CERTIFICATE OF DEATH

10272

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS Ad5

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Walton Hotel, 202 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Edward Lewis Smith

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widowed |

6.(b) Name of husband or wife: Kathryn E. Schmutz

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 6 | ~~68~~ | ..... hrs. ..... min. |

8. Birthplace: Cumberland Allegany Md.
(Town, county, and state)

10. Usual occupation: Machinist (retired)

11. Industry or business: Railroad

FATHER
12. Name: Henry W. Smith
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Jennie Hackenberg
15. Birthplace: Wheeling, W. Va.

16. Informant: William H. Smith
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28 1940 (month) (day) (year)

Cemetery or crematory: Rosehill Cemetery

Location: Cumberland, Md.

18. Funeral director: Jacob Hafer

Address: 230 Baltimore Ave, Cumberland

19. Oct. 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. W. F. Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 10-25- 1940 at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-24- 1940, to 10-25- 1940 and that I last saw h... alive on 10-25- 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocardial Disease. | |
| Due to Coronary Sclerosis | ? |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other

Address: Cumberland, Md. Date signed: 10/28/40.

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

## CERTIFICATE OF DEATH

10273

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or towo limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 410 Decatur St

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If ootside city or town limits, write RURAL and give nearest town)

Street No. 410 Decatur

(If roral, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Jane Frances Smith

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | widowed |

6.(b) Name of husband or wife: John R. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22 - 1852

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 4 | 17 | ..... hrs. ..... min. |

9. Birthplace: Frostburg - Alleg - Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Nathan Arnold

13. Birthplace: Mt. Savage

MOTHER 14. Maiden name: Helen Wade

15. Birthplace: Pa.

16. Informant: Frances Smith

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12-1940 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Frostburg

18. Funeral director: J. J. Arnold

Address: Frostburg, Md.

19. Oct. 9 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 10-8-40 19..... at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 2 19 40 to 10-8-40 19

and that I last saw h.. alive on 10-8-40 19

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | 2 mos. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Alfred Van Demark M. D. or other

Address: Cumb. Md. Date signed 10-8-40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

10274

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 35 MIN.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 841 GEPHART DRIVE, CITY
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** BABY NATALEE SPEAR

**3. (b) Social Security Number** None

4. Sex: FEMALE | 5. Color or race: WHITE | 6.(a) Single, married, widowed, or divorced: SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 22, 1940

**8. AGE:** Years: 7 MONTHS | Months: | Days: 4 | If less than one day ..... hrs. ..... min.

8. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER
12. Name CHARLES SPEAR
13. Birthplace POLAND

MOTHER
14. Maiden name PAULINE SHARON
15. Birthplace NEW YORK

16. Informant Charles Spear

Address 841 Gephart Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 27, 1940 (month) (day) (year)

Cemetery or crematory Jewish Cemetery

Location Cumberland Maryland

18. Funeral director Louis Stein Inc.

Address Cumberland, Maryland

19. Oct. 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 26 1940, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26 1940, to Oct 26 1940 and that I last saw her alive on Oct 26 1940

Immediate cause of death: Edema of glottis — DURATION: 3 hours (?)

Due to: Acute Tracheolaryngitis probably streptococcic (cultures taken)

Other conditions

(Include pregnancy within 3 months of death)

~~Major findings of~~ operations Tracheotomy done and Laryngoscopy after death Date of op. 10/26/40

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Samuel H. Jacobson Mrs. M. D. ~~or other~~

Address 119 Bedford St Date signed 10/26/40

DR. JACOBSON

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
U. S.

Outside of City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

10275

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland R.D.#2.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland R.D.#2. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Martha LeVina Stafford

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: George Stafford

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Apr. 27, 1862

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 5 | 18 | ____ hrs. ____ min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Hanson Bucy
13. Birthplace: Penna.

MOTHER
14. Maiden name: Elizabeth Plummer
15. Birthplace: Penna.

16. Informant: Mr. John W. Stafford
Address: Cumberland, R.D.#2.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 17, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Herman

Location: Williams Road

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Oct. 16 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15, 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1940 to Oct 15 1940, and that I last saw her alive on Oct 14 1940.

Immediate cause of death: Uremic Coma — DURATION: 2 days

Due to: Chronic Nephritis — 5 years

Due to:

Other conditions: Organic Heart Disease — 5 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Shaw-N. Kaan M. D. or other

Address: Cumberland Md. Date signed: 10/15/40

VS A15 (M) (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

10276

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mt Savage

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 49 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Yellow Row.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Minnie Pearl "Yantz" Stevens

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed. |

6 (b) Name of husband or wife Walter Stevens.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 3 | 5 | hrs. min. |

9. Birthplace Hyndman, Bedford, Pa.

(Town, county, and state)

10. Usual occupation Housework at Home

11. Industry or business

FATHER 12. Name James Yantz

13. Birthplace Hyndman, Pa.

MOTHER 14. Maiden name Lilly Thorpe

15. Birthplace Mt Savage, Md.

16. Informant Chester Stevens

Address Mt. Savage Md.

17. Burial Date thereof Oct 21, 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Episcopal

Location Mt Savage

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. Oct 19 1940 H. J. Bostetter M.D.

(Date rec'd by registrar) Local Registrar

Bostetter

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1940, at 2.20 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct 17 1940, to Oct 19 1940, and that I last saw her alive on Oct 18 1940.

Immediate cause of death Cerebral Hemmorhage — DURATION 2 days

Due to Hypertension — DURATION 4 yrs.

Due to Arterio Sclerosis — DURATION 10 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D.

M. D. or other

Address Mt Savage Md. Date signed Oct 19. 40

RECEIVED
NOV 2 1940
BUREAU V. M.

WITHIN CORPORATE LIMITS

10277

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(48-B)

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 mos.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 440 Goethe St

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME** Ruth Helen Stitcher

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: John H Stitcher

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Aug 10 1902

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 2 | 10 | hrs. min. |

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER

12. Name: Alonzo Rice

13. Birthplace: Md

MOTHER

14. Maiden name: Imogene Beall

15. Birthplace: Md

16. Informant: John H Stitcher

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23 40 (month) (day) (year)

Cemetery or crematory: Evergreen Cumb

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Oct 23 1940 (Date rec'd by registrar) J. C. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1940, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 1940, to Oct. 19, 1940

and that I last saw her alive on October 19, 1940

Immediate cause of death: Adenocarcinoma of uterus — DURATION: 2 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Diagnostic curettage showed adenocarcinoma of uterus 6-25-40 Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: Cumberland, Maryland Date signed: 10-21-40

RECEIVED
NOV 6 1940
BUREAU V. S.

Dr Gatten

102789

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

Reg. Dist. No. .....

**1. PLACE OF DEATH:**

County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Rachel Eckhart Strachan

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Robert Strachan

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1866

**8. AGE:** Years: 74 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Eckhart Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER
12. Name: John Eckhart
13. Birthplace: Eckhart Md.

MOTHER
14. Maiden name: Mary Meyers,
15. Birthplace: Cumberland Md.

16. Informant: Mrs. Janet Kidwell,
Address: Eckhart, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 13, 1940
(month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

18. Funeral director: J. J. Durst,
Address: Frostburg, Md.

19. Oct 13 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10, 1940, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1940, to Oct. 10 1940 and that I last saw her alive on Oct. 10 1940.

Immediate cause of death: Acute Pulmonary Edema — DURATION: 1 hr.

Due to: Chronic Asthma & Myocarditis — 10 yrs.

Due to:

Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. E. Gatten M.D. (M. D. or other)

Address: Frostburg, Md. Date signed: 10/12/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

## CERTIFICATE OF DEATH

10279

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: 701 Fairmont Ave.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 701 Fairmont
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Charles Clary Sullivan

**3.(b) Social Security Number:** None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Virginia Mary Wright
6.(c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Sept 3 1874

**8. AGE:** Years: 66 | Months: — | Days: 29 | If less than one day: ...hrs. ...min.

9. Birthplace: Westernport Md. (Town, county, and state)
10. Usual occupation: Retired R.R. Employee
11. Industry or business:

FATHER
12. Name: Patrick J Sullivan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Griffin
15. Birthplace: Md.

16. Informant: Mrs Virginia M Sullivan
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 40 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Oct. 3 1940 (Date rec'd by registrar) J. P. Buckley M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1940, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 st 1940, to Oct 1 1940
and that I last saw him alive on Sept 30, 1940 1940

| | DURATION |
|---|---|
| Immediate cause of death: Coronary Thrombosis | 15 min |
| Due to: Hypertension Cardiac Vascular Renal Disease | Unk |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. W. Schindler M.D. M. D. or other
Address: 41 Irene St. Date signed: Oct 4 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

## CERTIFICATE OF DEATH

Reg. Dist. No. 8 — 18280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15 (T) (1) (M)

**1. PLACE OF DEATH:**
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred: Big Vein Hill
How long in hospital or institution? 2

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Big Vein Hill
(If rural, give LOCATION)
2.(a) If veteran, name war: 2

**3. (a) FULL NAME:** Howard G. Thomas

**3. (b) Social Security Number:** 3

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Dorothy Tuspan
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec. 22 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 9 | 26 | ... hrs. ... min. |

9. Birthplace: Frostburg, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Retired Railroad Clerk
11. Industry or business: Railroad Co.

FATHER
12. Name: William Thomas
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Marian Hutchinson
15. Birthplace: Lonaconing, Md.

16. Informant: Mrs. Margaret Gardner
Address: Lonaconing, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 22 1940 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: M. Eichelberger
Address: Lonaconing, Md.

19 Oct. 21 1940 E. Dan Taylor
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** short

20. DATE OF DEATH: October 18th 1940 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

| Immediate cause of death | DURATION |
|---|---|
| Suicide by illuminating gas (inhalation) | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 10-18-40
Where did injury occur? Lonaconing (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: illuminating gas Injured at work? no

23. SIGNATURE: Thomas H. Bowen M.D. (M. D. or other)
Address: Cumberland, Md. Date signed: 10-19-40

Deputy Medical Examiner - Allegany Co.

RECEIVED
NOV 7 1940
BUREAU Y. S.

WITHIN CORPORATE LIMITS.

M

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

10281

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 622 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**
WAGNER, BABY BOY (STILLBORN)

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 10, 1940

8. AGE: Years | Months | Days — Stillborn | If less than one day ..... hrs. 0 min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name CARL WAGNER
13. Birthplace MARYLAND, Cumberland

MOTHER
14. Maiden name MARGUERITE STERNE
15. Birthplace WEST VIRGINIA, Piedmont

16. Informant Mr. Carl Wagner
Address 622 Bedford St. City

17. Cremation Date thereof Oct. 10 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Destroyed

Location at

18. Funeral director Hospital

Address

19. Oct. 14 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 10, 1940, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw him ~~alive~~ dead on Oct 10/40 19.....

Immediate cause of death — DURATION

abortion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Knight Reynolds M.D.
M. D. or other

Address Cumberland Md Date signed Oct 11/40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

10282

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town FRIENDSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Ruby Wakefield

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Infant |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1939

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 4 | — | hrs. min. |

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name John L. Wakefield
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah VanSickle
15. Birthplace Maryland

16. Informant JOHN WAKEFIELD
Address FRIENDSVILLE, MD.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 23 1940 (month) (day) (year)
Cemetery or crematory Bloomington Rose
Location Garrett Co. Maryland
18. Funeral director W. H. Stevens
Address Friendsville Md

19. Oct. 21, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 21, 1940, 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1940, to Oct. 21 1940
and that I last saw h[illegible] alive on Oct. 20 1940

| Immediate cause of death | DURATION |
|---|---|
| Bilateral Lobar Pneumonia | 1 WK. |
| Due to Malnutrition | 6 WK. |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. A. Eliason M. D. or other
Address 126 Union St. Cumberland Md Date signed Oct 21 40

DR. ELIASON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B)

10283

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 61 yrs.
Hospital, institution or street address where death occurred: 748 Columbia St.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 748 Columbia St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Blanche B Weigand

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 1 | 5 | hrs. min. |

9. Birthplace Cumberland, Allegany Co Md
(Town, county, and state)

10. Usual occupation none.

11. Industry or business

FATHER 12. Name Wm Weigand
13. Birthplace Cumberland Md

MOTHER 14. Maiden name Isabelle Fries
15. Birthplace Cumberland Md

16. Informant Mrs Frank J Greenwade
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 '40 (month) (day) (year)

Cemetery or crematory St Johns Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Oct. 29 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1940, at 4 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 15 1940, to Oct 26 1940
and that I last saw her alive on Oct. 25" 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Stomach | 1 yr. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter R. Draut MD
M. D. or other
Address Cumberland Md. Date signed Oct 26/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A 15

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10284

93-d

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
214 Harrison St.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214 Harrison St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Edna J. Whistler

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife Walter C. Whistler
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 13 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 6 | 10 | hrs. min. |

9. Birthplace Keyser W. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business at Home
FATHER 12. Name Edgar H Davis
13. Birthplace Winchester Va.
MOTHER 14. Maiden name Lucy Cromwell
15. Birthplace W. Va.
16. Informant Mrs Nellie E Dayton
Address Cumberland.
17. Bruise Date thereof Oct 16 40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Queens Pt. Cem.
Location Keyser W. Va.
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. Oct. 25 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1940, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940, to Oct 23 1940
and that I last saw her alive on Oct 23 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 2 yrs. |
| Due to — | — |
| Due to | |
| Other conditions Arteriosclerosis | 3 yrs. |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. St. Trevorskis, M.D.
M. D. or other
Address Cumberland, Md. Date signed Oct 24-40

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10285

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 wks.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 Waverly Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME** John J. Wigman.

**3.(b) Social Security Number** 220-10-7143

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4 1881

**8. AGE:** Years 59 | Months 3 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Celanese Corp.

FATHER
12. Name: Henry V Wigman
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Helen Mowery
15. Birthplace: Md

16. Informant: Ed P. Wigman
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26 40 (month) (day) (year)

Cemetery or crematory: Sts Peter & Paul's Cem

Location: Cumberland Md

16. Funeral director: Louis Stein Inc

Address: Cumberland

19. Oct 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 24 1940, at 2 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/2/40 19..., to 10/24 1940 and that I last saw her alive on 10/23/40 19...

Immediate cause of death: chronic myocarditis.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John K Rozman M.D. M. D. or other

Address: Cumberland Md Date signed: 10/23/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10286

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(83a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, Institution, or street address where death occurred: 15 S. Liberty St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 S. Liberty St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Maud Lee Wilson

**3. (b) Social Security Number** none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Oliver S Wilson

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 12 1866

**8. AGE:** Years 74 Months 3 Days 1 If less than one day ... hrs. ... min.

9. Birthplace Hampshire Co. W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER
12. Name Solomon Pugh
13. Birthplace W. Va.

MOTHER
14. Maiden name Margaret McDonald
15. Birthplace W. Va.

16. Informant Wilbur Wilson

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 '40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Oct 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13th 1940, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from — 1930, to Oct. 13th 1940 and that I last saw her alive on Oct. 12th 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 11 dys |
| Due to High Blood Pressure | |
| Due to Undetermined | |
| Other conditions 4 cart block | 3 yrs. |

(Include pregnancy within 3 months of death)

Major findings of operations —

— Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charlotte B Gardner M. D. or other

Address Cumberland Date signed Md.

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

## CERTIFICATE OF DEATH

10287

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 yrs.
Hospital, Institution or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 9 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 408 Hill St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Bertha M. Woolard.

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife Thos E Woolard
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 11 | 20 | hrs. min. |

9. Birthplace Cumberland Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
FATHER 12. Name John A Sills
13. Birthplace Md.
MOTHER 14. Maiden name Catherine Beasley
15. Birthplace Md.
16. Informant Thos E Woolard.
Address Cumberland
17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 17 '40 (month) (day) (year)
Cemetery or crematory Hillcrest Cem.
Location Cumberland Md.
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. Oct. 17 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct. 14, 1940, at 5:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Oct. 14, 1940
and that I last saw her alive on Oct. 14, 1940

| Immediate cause of death | DURATION |
|---|---|
| Fracture of right femur. | 10 days |
| Due to | |
| Due to | |
| Other conditions Carcinoma of uterus | 3-4 mo. |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 10-5-40
Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home.
Means of injury Fell Injured at work? No

23. SIGNATURE C. S. Zimmerman M.D.
M. D. or other
Address 105 S Centre St. Date signed Oct 16, 1940
Cumberland Md.

RECEIVED
NOV 6 1940
BUREAU V. S.